RONALD FANTOZZI

3 OF 18

St. Mary's Regional Medical Center
Pre-Op Admission Assessment

DAY SURGERY 3/23/01 1445280
MD 221342 MAILHOT, PAUL
FANTOZZI, RONALD M
40 POLAND RD
AUBURN ME 04210
DOB [redacted]/62 TEL 782-3873
036035921-02 3021616

Admission Date 3-23-01 Time 0800
Procedure LT ESWL
LOC alert
Ventilating Well Yes ✓ No ____
Comments ____

	YES	NO	N/A
Pre-Admission Testing Reviewed	✓		
Abnormal Testing Report			
PAT Anesthesia Visit			
Pre-Op Teaching:			
Verbal instructions given, D.S. routine IV's Meds	✓		
Plan for Nursing Care Reviewed	✓		
Patient/Family express understanding of instructions	✓		
Emotional Support	✓		

Pre Surgery Checklist	YES	NO	NA
Doctor's orders noted and complete	✓		
Foley inserted if ordered			✓
Time voided ____ Cath drained ____ Amount ____			
Height 5'3 Weight 77.3			
Makeup, fingernail polish removed			
Address-o-graph plate on chart	✓		
Dentures removed			
Jewelry removed/covered			
Advanced directives on chart			
IV ordered			

Site RA Cath. 20g By [signature]

Signature [signature] RN/LPN

Pre-Op Medication

V/S prior to premeds T 36.7 P 80 R 18 BP 126/82
Pre-Medications Sublimaze 50 mcg IM 9:15 [signature]

V/S post premeds P____ R____ BP____
P____ R____ BP____
P____ R____ BP____

Eye Drops to OD____ OS____
Ocufen .03% 1 Gtt on Adm____ & to OR____
Madriacyl 1% 1 Gtt Q5 min x4 ____ ____
____ ____
Mydfrin 2.5% 1 Gtt Q5 min x4 ____ ____
____ ____

Initials ____ Signature ____
Initials ____ Signature ____
Initials ____ Signature ____

Peri-Orbital Block

Monitor Pattern ____
Oxygen Saturation Pre ____ %
Versed mg. IV @____ by____ RN
Other Meds ____

Time____ BP____ P____ R____ SAT____ %
Time____ BP____ P____ R____ SAT____ %
Time____ BP____ P____ R____ SAT____ %
Time____ BP____ P____ R____ SAT____ %
Time____ BP____ P____ R____ SAT____ %

Oxygen started at ____/LPM via N/C Time ____
Block To OS/OD by Dr.____ @____
Lid closed, taped, reducer in place P block ____
Block supplemented YES___ NO___ Time ____
Signature____ RN/LPN

500685.011.0031

3 POLAND RD
GBUR
08 2/16/
06603921 -

DAY SURGERY NURSING ASSESSMENT

POST-OP PROCEDURE PHASE OF STANDARD CARE PLAN — TIME AND NUMBER PER CODE

Code	Description		1125	1155	1225				
2 -	Able to deep breath and cough								
1 -	Short of breath								
0 -	Apneac	A	2	2	2				
2 -	V.S. stable and within pt.'s normal limits								
1 -	V.S.'s irregular or fluctuating	B	2	2	2				
0 -	Unable to palpate B/p or pulse								
2 -	Extremities have full sensation Lower Rt/Lt, Upper Rt/Lt								
1 -	Extremities have partial sensation Lower Rt/Lt, Upper Rt/Lt	C	2	2	2				
0 -	Extremities are without sensation Lower Rt/Lt, Upper Rt/Lt								
2 -	Skin - Warm, Pink								
1 -	Skin Cool, Pale	D	2	2	2				
0 -	Skin - Cool, Cyanotic								
2 -	No surgical bleeding site								
1 -	Small amount of surgical bleeding	E	2	2	2				
0 -	Large amount of surgical bleeding								
2 -	Free of pain								
1 -	Minimal pain	F	2	2	2				
0 -	Moderate to severe pain								
2 -	Tolerating P.O. fluids								
1 -	Not taking P.O. fluids	G	2	2	2				
0 -	Nausea / Vomiting								
2 -	I.V. discontinues, Cath. Intact 950 ml. infused.								
1 -	I.V. patent @ KVO	H	1	1	1				
0 -	No I.V. ordered								
2 -	Voiding without problems								
1 -	Has not voided.	I	1						
0 -	Needs to be cathed.								
2 -	Fully awake								
1 -	Arouses when called	J	2	2	2				
0 -	Unresponsive								
2 -	Up ad lib		0	0					
1 -	Up with assistance								
0 -	On bedrest	K	BP	BP	BP				

TIME	TEMP	P	R	B/P	INIT	COMMENTS
						Up + steady. O2 sat 93-94%.
1125	—	84	16	120/60	B[illegible]	[illegible] taking po
1155	36.7	82	16	118/70	BP	awake / alert. O2 sat 96%
1225	—	86	16	110/62	BP	
1245					BP	up & voided 200 ml dk tea c̄ shreds
						steady. O2 sat 97%. Alert/awake
						[illegible]

TIME	MEDICATION - ROUTE	INIT	

Discharge Order by Surgeon Yes ✓ No ____ Cleared for discharge by Anes. Yes ✓ No
Seen by Surgeon ✓
Discharge Teaching per Standard Care Plan to: Patient ✓ Family ✓ Other ____ Init. BP
D.C. Time & Mode W/C 1315 Follow-up appointment 4/30 ✓ D.C. Criteria met: Yes ✓ No ____

Activity (1) 2 3 4 Restrictions (1) 2 3 4
Diet (1) 2 3 4 S/S Infection (1) 2 3 4
Drsg. Care (1) 2 3 4 Complications
Written Rx. (1) 2 3 4

RESPONSE CODE
1 - Verbalizes understands
2 - Requires reinforcement
3 - Refuses
4 - N/A

Signature: Marie Blorigu[illegible] Init. MB

500685.011.0032

Please report to
ANESTHESIA INTERVIEW
1ST FLOOR BY DAY SURGERY
Date:
Time:

t. Mary's Regional Medical Center

Pre-Admission Testing Office
Campus Avenue, P.O. Box 291
Lewiston, ME 04243-0291
Telephone 777-8236, Fax 777-8224

P.A.T. Testing Orders

DAY SURGERY
MR 221342
FANTOZZI, RONALD M
40 POLAND RD
AUBURN ME 04210
DOB [redacted] /62 TEL 782-3873
006605921-02 3021618

☐ Admission
☐ Early A.M. Admission
☑ Day Surgery
3/23/01 1445280
MALLIOT, PAUL

Patient Name Ronald Fantozzi
Address
Age: _____ Date of Birth: _____ Telephone No. _____
Insurance #1 _____ Subscriber _____ Employer _____
Insurance #2 _____ Subscriber _____ Employer _____
Admitting Physician's Name: _____ Referring Physician: _____
Admission Date: _____ Surgery Date: March 23rd
Diagnosis: (L) Ureteral Calculus
Procedure: ESWL
Date Test Ordered: _____ Physician's Signature: P A Malliotis

☑ Anesthesia Interview Time In _____ Time Out _____

☐ Pre-Admission Testing Time In _____ Time Out _____ Fasting ☐

☐ **Laboratory**

- ☐ CBC, AUTO DIFF
- ☐ HGB
- ☐ HCT
- ☐ PLATELETS
- ☐ COAG PROFILE
- ☐ BLEEDING TIME
- ☐ COMP. METABOLIC PANEL *
- ☐ CO2
- ☐ ELECTROLYTES
- ☐ RCIF
- ☐ SODIUM (NA)
- ☐ POTASSIUM (K)
- ☐ GLUCOSE (8 HRS FASTING) *
- ☐ BUN
- ☐ CREATININE
- ☐ URINALYSIS, ROUTINE
- ☐ URINALYSIS, CULTURE
- ☐ BASIC METABOLIC PANEL
- ☐ HEPATIC FUNCTION
- ☐ AMYLASE
- ☐ TYPE & SCREEN
- ☐ TYPE & MATCH FOR _____ UNITS
- ☐ AUTOLOGOUS _____ UNITS
- ☐ QUALITATIVE HCG
- ☐ CHEMICAL PREGNANCY
- ☐ OTHER: _____

FASTING: NO FOOD OR LIQUIDS EXCEPT WATER
*** 8 HOURS ** 14 HOURS**

☐ **Cardiology**

- ☐ EKG
- ☐ ECHO
- ☐ STRESS ECHO
- ☐ CHEMICAL STRESS ECHO
- ☐ OTHER
- ☐ APPT TIME & DATE: _____

☐ **Radiology** Time in: _____ Time out: _____

- ☐ CHEST
- ☐ OTHER: _____

☐ **Respiratory**

- ☐ ABG
- ☐ PULMONARY FUNCTION TEST
- ☐ SIMPLE PFT
- ☐ PRE & POST BRONCHODILATION
- ☐ OTHER: _____

Appointment Time & Date: _____

Special Instructions: _____

140204

Please Return to Pt. Representative Office (located across from lab) following Testing & Interview

500685.011.0033

St. Mary's Regional Medical Center
DOCTOR'S ORDER FORM

DAY SURGERY 3/23/01 1445280
MD 221342 MAILHOT, PAUL
FANIZZI, RONALD M
40 POLAND RD
AUBURN ME 04210
DOB [redacted]/62 TEL 782-3873
006605921-02 3021616
ADDRESSOGRAPH IMPRINT

Please Check ONE

- ☐ Inpatient Admission (I)
- ☐ 23 Hour Observation (Outpatient) (V-O)
- ☐ Day Surgery (Home Same Day) (D-Z)
- ☐ Day Surgery (With Overnight) (D-Z)
- ☐ Day Surgery to 23h Observation (V-O)
- ☐ Admit as Inpatient to Observation Room on Med/Surg (I)

Diagnosis: _____

Allergies: _____

Date	Time		Initial When Faxed
3/23/01		Gentamycin 80 mg IV ✓ Keflex (2) oblique extend Emla pre Edoc ✓ LR KVO vs Dr. Mailhot / Polaroid Noted Polaroid in Mailhot	

ORIGINAL FOR CHARTS

120113 DOCTOR'S ORDER FORM Rev 01-2001

500685.011.0034

St. Mary's
REGIONAL MEDICAL CENTER

SURGICAL DAY CARE DISCHARGE INSTRUCTIONS

DAY SURGERY 3/23/01 1445280
PT 221342 MAILHOT, PAUL
[illegible]21, DONALD M
43 POLAND RD
AUBURN
[illegible] ME 04210
[illegible]/62 TEL 782-3873
[illegible]21-02 3021616

1. Following lithotripsy you might expect:
   a. Blood in urine
   b. Discomfort in your flank area from the kidney stone particles
   c. Mild bruising at the treatment site
   d. Mild nausea for 24-48 hours
   e. Mild fever of less than 101F. for 24-72 hours

2. Contact your physician if you experience:
   a. Pain-not controlled by oral medications
   b. Fever greater than 101F.
   c. Inability to urinate for more than six hours
   d. Persistent nausea and vomiting
   e. Severe bleeding
   f. Any other unexplained symptoms or problems

3. Care at home:
   a. Force fluids-drink eight to ten glasses of water a day.
   b. Strain your urine as directed by your physician. Collect any particles strained from the urine, place them in the container provided and bring them with you to your physician's office on your follow-up appointment.
   c. Take medications as directed. If you have any questions regarding them, contact your urologist.
   d. Do not take aspirin or aspirin products such as Bufferin, Bayer or Alka Seltzer until checking with your urologist.
   e. If you have mild pain, you may take Tylenol(Two every four hours as needed). For other symptoms please see below.

Other Medications:	MEDS	DOSE	SCHEDULE
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

   f. Other Instructions_____

4. Follow-up appointment:
   To insure a safe recovery, it is important that you keep your follow-up appointment regardless of how you feel. This will assist your physician in determining your status. Call your doctor's office tomorrow, or the next business day to schedule your appointment, with follow-up-X-Ray.
   Dr.:_____ Tel:_____
   A member of the CT Litho staff will attempt to call you at home two days after the procedure. Please call your physician for any acute problems.
   In an emergency, go to the nearest hospital Emergency Department!
   Date:_____ Person Receiving Instructions:_____
   Person Dispensing Instruction:_____

500685.011.0035

ST. MARY'S REGIONAL MEDICAL CENTER
DAY SURGERY UNIT - DISCHARGE INSTRUCTIONS

DAY SURGERY 3/23/01 1445280
MD 221342 MAILHOT, PAUL
PANTOZZI, RONALD M
40 POLAND RD
ALBURY ME 04210
DOB [redacted]/62 TEL 782-3873
036009921-02 3021616

CALL YOUR PHYSICIAN FOR:

1. Temp. above 100 or severe chills.
2. Persistent nausea/vomiting
3. Excessive swelling, redness, bruising, tenderness around incision.
4. Excessive bleeding or drainage on the dressing.
5. Severe pain unrelieved by pain med.
6. If surgery on arm, leg or hand, report excessive swelling, discoloration or numbness.

IF UNABLE TO REACH YOUR PHYSICIAN, YOU MAY CALL: ST. MARY'S EMERGENCY ROOM AT 777-8120.

ACTIVITY: as tolerated

For the remainder of the day, stay at home and rest.
You may be sleepy up to 24 hours.
NO DRIVING or operating hazardous machinery for 24 hours.
Check with your doctor if you have any questions about returning to work, sports, or strenuous physical activity.
AVOID MAKING MAJOR DECISIONS TODAY.
DO NOT SIGN ANY IMPORTANT PAPERS TODAY!

HYGIENE: NO baths or showers on the day of surgery.
You may resume baths/showers in _____ days.

DIET: NO alcohol for 24 hours following your surgery.
Begin with liquids and EAT LIGHTLY at first - continue to eat and drink small amounts at a time - at frequent intervals, today.

DRESSING: Keep dressing clean and dry. You may remove and/or change dressing in _____ days.
If surgery on arm or hand, elevate above chest level to prevent swelling and decrease discomfort.

MEDICATION INSTRUCTION:
Macrobid as prescribed
Pain medicine as prescribed as needed

ADDITIONAL INSTRUCTIONS:
- diet as tolerated - drink plenty of fluids -
- see attached sheets
office appt - FRIDAY 3/30 at 330pm HAVE KUB Xray prior to office 3/30 at 230 visit at Central Maine Imaging. TAKE Xrays with you to office

FOLLOW - UP APPOINTMENT

DOCTOR: Mailhot OFFICE #: 783-7892 DATE: 1 week TIME: 3/30 - 3:30

I HAVE READ AND UNDERSTOOD THESE INSTRUCTIONS: _____
(Patient's Signature, Date & Time)

Accompanying Adult's Signature: Ronald Pantozzi (If applicable) DATE: 3/23/01 TIME: 1310 am/pm

Staff Witness: _____ DATE: _____ TIME: _____ am/pm

St. Mary's Regional Medical Center

Patient Valuable List

DAY SURGERY 3/23/01 1445280
MR 221342 MAILHOT, PAUL
FANTOZZI, RONALD M
40 POLAND RD
AUBURN ME 04210
DOB [redacted]62 TEL 782-3873
006605921-02 3021616

(X)	Item	Description
X	Eye Glasses	
Ø	Hearing Aid(s)	
Ø	Dentures/Partials	
Ø	Money	
X	Jewelry	wedding Band
Ø	Canes, Walker, Wheel Chair	
Ø	Medication **(please send home if possible)**	
X	Other	Clothes

Release from Responsibility for Personal Property

I understand and agree that under no circumstances will St. Mary's be responsible for my personal property . I take full responsibility for retaining in my possession or custody any and all articles. I acknowledge that I have declared or listed all items of personal property I have chosen to keep in my possession or custody while at St. Mary's, and further acknowledge that I have been offered an opportunity to have my personal property kept in safe keeping at St. Mary's during my stay at St. Mary's, and that I have refused that offer.

Patient/Guardian Signature [signature] Date _____

SMANURSINGFORMS.PMJ

140030

500685.011.0037

ST. MARY'S REGIONAL MEDICAL CENTER
PATIENT ADMISSION ASSESSMENT

DAY SURGERY 3/23/01 1445280
MR 221342 MAILHOT, PAUL
FANTOZZI, RONALD M
POLAND RD MAILHOT, PAUL
AUBURN RONALD ME 04210
DOB 4/16/62 TEL 782-3873
ACCOUNT 006605921-02 3021616
DOB 4/16/62 TEL 782-3873
006605921-02 3021616
addressograph imprint

ROOM #	DATE PATIENT TO UNIT:	TIME TO UNIT:	AMBULATORY STRETCHER WHEELCHAIR

CONTACT PERSON:	RELATIONSHIP	PHONE NO.
Debra	wife	7823873

DIAGNOSIS: Rt. Ureteral Calculus

COMMUNICATION: Language Preference: English ☐ French ☐ Other ☐
* Family Translator _____ (requires release from patient) * Other Translator _____ * Phone No _____

Allergies: Medications: No ☐ Yes (specify): Vancomycin
Foods: No ☐ Yes (specify): _____
Latex: No ☐ Yes ☐

BP _____ T _____ P _____ R _____

Wgt 193 Kg Ht 5 ft 8 in (actual / stated)

Hearing:	Vision:	Disabilities:	Teeth:	Dentures:
☑ normal	☐ normal	☐ speech	☑ intact	☐ full
☐ impaired	☐ impaired	☐ MR	☐ loose	☐ partials
☐ aides	☐ blind	☐ other	☐ none	☐ plates
☐ Rt.	☑ glasses		☐ top	☐ top
☐ Lt.	☐ contacts		☐ bottom	☐ bottom

Brief History of Present Illness: Rt ureteral stone for 1 month

Pertinent Medical History:

- ☐ no major problems
- ☐ unable to obtain history
- ☐ psychological/emotional anxiety Manic attacks
- ☐ cardiovascular (CVA, HTN, chest pain, etc) Chronic bronchitis
- ☐ respiratory (TB, COPD, asthma, etc)
- ☐ genitourinary
- ☐ gastrointestinal (ostomy, diarrhea, constipation) Crohns ~~Chron~~
- ☐ neurological (seizures, etc)
- ☐ integumentary
- ☐ musculoskeletal
- ☐ diabetes
- ☐ kidney disease Multiple calculi
- ☐ cancer
- ☐ blood disorders
- ☐ transfusion reactions
- ☐ reaction to anesthesia
- ☐ other

Comments: Type C Hepatitis

Implantable devices:
☐ pacemakers ☐ intrathecal pumps ☐ other (specify)
☐ ports / central lines ☐ deep brain stimulator (DBS)

Pertinent Surgical History: (Include dates)
1) Appendectomy
2) Colon resection
3) Cholecystectomy
4)
5)
6)
7)

Medication Profile:

Drug Name (Include Rx, OTC, Herbal Supp.)	Dose:	Frequency	Date/Time of Last Dose	Reason for Taking Med	Taken as Ordered Yes/No	Side Effects, If Any
Mycostatin	500,000 units	four times daily				
Klonopin	1 mg	daily				
Lasix	40 mg	daily				

RN/LPN Signature [signature] RN/LPN Signature _____

Fax to Pharmacy RN/LPN Signature _____ RN/LPN Signature _____

140228 rev. 7/00

REGISTRATI [XX] ADMISSION [ ]

ST. MARY'S R[illegible]ONAL MEDICAL C[illegible]TER
LEWISTON, M[illegible]4240

ADM NO	FC	ARRIVED	MED REC #	PATIENT NAME	SVC	NS/ROOM/BED	REG DATE
1431040	C	DNSP	221342	FANTOZZI, RONALD M	GEN	0000	3/09/01

PATIENT ADDRESS	AGE	D.O.B.	PLACE OF BIRTH	SEX	MARITAL STATUS
40 POLAND RD	038Y	[redacted]62	CT	M	M

CITY, STATE, ZIP	MAIDEN NAME	MOTHER/FATHER NAME
AUBURN ME 04210		

ATTENDING PHYSICIAN	NEXT OF KIN/SPOUSE	NEXT OF KIN/TELEPHONE NO
MAILHOT, PAUL R	DEBORAH FANTOZZI	207 7823873/

REFERRING PHYSICIAN	RACE/SMOKE	RELG	PREV DISCH	EMS NO
BOULANGER, MICHAEL J	C	81	10/05/98	

PRIMARY CARE PHYS	DATE/TIME ADMITTED	DATE/TIME DISCH/DEATH
BOULANGER, MICHAEL J	3/09/01 8:23	3/09/01 1510

PT PHONE #	ADMIT BY	SOC SEC #	LOCATION	ADMITTING DIAGNOSIS
207 782-3873	4310	[redacted]-2724		

EMPLOYER PHONE #	GUARANTOR(NAME/ADDRESS)	VETERAN	XRAY NO
	FANTOZZI, RONALD M 40 POLAND RD AUBURN ME 04210		08-99-89

ADVANCE DIRECTIVE	POWER OF ATTORNEY	LIVING WILL
	NONE	NONE

INSURANCE CO #/NAME	POLICY NO	GROUP NUMBERS	SUBSCRIBERS NAME(S)	RELATION
92 7 CIGNA/AVON CT	006605921-02	3021616	FANTOZZI, DEBORAH	SP
50 21 MEDICARE	006542724A		FANTOZZI, RONALD M	PT

DIAGNOSIS
LT URETERAL CALCULUS / LT URETEROSCOPY, STONE EXTRACTION, STENT PLACEMENT

COMMENTS	TRANS OR ADMIT	DATE LAST SERVICE	PHYSICIAN
PM		10/05/98	02713

PATIENT INFORMATION

EMPLOYER NAME	EMPLOYER ADDRESS			
CITY	ST	ZIP	PHONE NUMBER	
		00000	(000)	

GUARANTOR INFORMATION

NAME		PT RELATION	ADDRESS
FANTOZZI	RONALD M	PT	40 POLAND RD

CITY	ST	ZIP	PHONE NUMBER
AUBURN	ME	04210	(207) 782-3873

SOC SEC NO	EMPLOYER	ADDRESS

CITY	ST	ZIP	PHONE NUMBER
		00000	(000)

SUBSCRIBER INFORMATION

NAME	SEX	PT RELATION	ADDRESS
FANTOZZI, DEBORAH	F	SP	

CITY	ST	ZIP	PHONE NUMBER
		00000	(000)

1ST INSURANCE CO NAME	ADDRESS	CITY	ST	ZIP
CIGNA/AVON CT	PO BOX 354	AVON	CT	06001

NAME	SEX	PT RELATION	ADDRESS
FANTOZZI, RONALD M	M	PT	

CITY	ST	ZIP	PHONE NUMBER
		00000	(000)

2ND INSURANCE CO NAME	ADDRESS	CITY	ST	ZIP
MEDICARE	PO BOX 9423	PORTLAND	MA	00000

NAME	SEX	PT RELATION	ADDRESS

CITY	ST	ZIP	PHONE NUMBER

Sisters of Charity Health System, Inc.
Consent/Benefits Authorization/Assignment
Of Benefits Statement

DAY SURGERY 3/09/01 1431040
PT 221342 HAILHOT, PAUL
40 PLEASANT ST PHY 0270
AUBURN
DOB 4/11/52 TEL 782-3873
00600502 02 3021610

Facilities:
☐ St.Mary's Regional Medical Center
☐ St. Marguerite d'Youville Pavillion

Admission Date: RONALD M
☐ Community Clinical Services,Inc.
☐ Sisters of Charity Health Systems, Inc

CONSENT FOR TREATMENT: The undersigned patient at the above-referenced facility ("Facility") hereby authorizes Facility's physicians and employees (and whomever they may designate as assistants) to administer such medical treatments as is necessary in their professional judgment, and such additional operations or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment. I further consent to the administration of such anesthetics as are necessary on the basis of findings during the course of said treatment. Any tissues removed may be disposed of by Facility in accordance with its customary practice. I have read and fully understand the above consent to treatment, and have had the reasons why the treatment or procedure is considered necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment explained to me by my attending physician. I understand that no guaranty or assurance has been made as to the results that may be obtained. I understand that authorized trainees may observe and assist in my diagnosis, treatment, and care.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO PAYORS AND TO OTHER HEALTH CARE PROVIDERS: Facility is hereby authorized and requested to furnish to any person who is or may be responsible for the payment of the charges incurred for my treatment at Facility, including any insurance company, third party administrator, my employer or any of their properly authorized agents or representatives, and any peer review organization which conducts reviews of hospital utilization under an agreement with my health insurance carrier, third party administrator or employer, or any person that is or may be liable therefore under contract or otherwise: all information required by it or them to determine benefits, including the nature of the visit, diagnostic and treatment information and copies of my medical record which may be available to Facility. Facility can disclose information to the persons so authorized on a continuing basis for as long as this authorization remains in effect. This authorization will remain in effect for the term of my current insurance coverage, along with any applicable renewals of that coverage.

I authorize Facility to release and discuss records regarding my medical care to other health care institutions, organizations or facilities as necessary to continue my care or treatment at the direction of my physician, and I authorize release of my medical records to health care providers to the extent such information is needed, in the professional judgment of Facility's personnel or my attending physician in order to provide for my medical treatment. Facility is further authorized to release all information required by nursing homes, boarding care facilities, home health agencies or congregate care facilities to assess appropriateness of my discharge to or referral for continuity of care by such facilities into other health care institutions, clinicians or facilities as necessary to continue my care or treatment. I understand that Facility may be required to obtain further consent from me with respect to the release of medical information that pertains to behavioral, chemical dependency, or HIV infection status, in accordance with applicable state and federal law.

I authorize the Facility to request an independent external review if an adverse health care treatment decision by the listed carrier occurs.

SPECIALIZED RELEASES: State and federal laws require my specific consent to disclose information pertaining to **HIV testing or treatment, mental health diagnosis and treatment, and/or drug, alcohol or other substance abuse** treatment information. I understand that I may request to review any information in my medical record, and may refuse to disclose some or all of my records. However, such refusal may result in improper diagnosis or treatment, denial of insurance benefits, or other adverse effects. I understand that my record may contain information pertaining to **HIV testing or treatment, mental health, and/or substance abuse treatment** and I agree to the release of this information by signing below.

Patient or legally authorized representative: Relationship Date:

Admission Form 12/2000
140209

DAY SURGERY 3/09/01 1431040
PAUL
PANIOZZI, ROMALD M
POA AND RP
DOB 4/16/62 TEL 782-3873
00660592I-02 3021616

I understand that I can refuse to release medical information for the purposes above listed. I also understand that if I refuse to release this information my insurance company or other person liable to bear my hospital expenses may not pay my expenses while I am treated at Facility and that refusal to release this information may result in improper diagnosis and treatment. I understand that this authorization to release medical information may be revoked (canceled) by me at any time. I understand that Facility may properly rely upon any authorization I have given to release medical information with respect to any disclosure made before revocation of such authorization.

PAYMENT TERMS: I understand payment of charges for medical care from Facility is due for services rendered within thirty (30) days of service unless otherwise determined by Facility, and that I will be responsible for any fee incurred by Facility for collection of delinquent charges or attorney's fees incurred in connection therewith. If I am financially unable to do so, upon request, I agree to complete a detailed financial statement so that alternative payment arrangements can be determined.

x RJF
PATIENT INITIALS

AUTHORIZATION FOR PAYMENT OF MEDICAL BENEFITS: I certify that the information given by me in applying for payment by the Medicare or Medicaid programs or any managed care provider is correct. I request that payment of authorized benefits be made to Facility and to physicians or organizations providing medical services to me or for my benefit. For extended outpatient services, I request that this authorization apply to the extent of my services. If I receive medical services, which are not covered by Medicare or Medicaid because those programs determine that the services are not medically necessary, I understand that I have the obligation to pay for those services. I agree to pay all charges for services not authorized for payment by any health maintenance organization, preferred provider organization or other managed care organization for which I seek certification for treatment by Facility.

ASIGNMENT OF BENEFITS: I hereby assign to Facility and related contracted professional service providers all hospital or professional service insurance benefits now due or which may become due and payable to me or on my behalf (but not to exceed the charges for such services) by virtue of my treatment at Facility, and I hereby direct any person including but not limited to, an insurance company, third party administrator, my employer, preferred provider organization or other person responsible for payment of my medical care to pay such benefit directly to Facility in consideration of the care, treatment and services furnished or to be furnished by or through Facility.

AN IMPORTANT MESSAGE FROM MEDICARE/CHAMPUS: I certify that I have received the Medicare Bill of Rights entitled "An Important Message From Medicare/Champus". Acknowledgement of receipt of this message does not waive any of my rights to request a review or make me liable for payment.

NOTICE: I understand Facility will provide information about my general condition and location within Facility in order to respond to questions about my condition, so I may receive telephone calls, visitors, mail, gifts or other deliveries, and to facilitate communications with the Facility's pastoral services department and clergy, except as required by law. I have been notified that by marking the box my name will be removed from the directory listing of persons cared for at the Facility, and understand that removal of my name from the directory may result in the inability of the Facility to direct visitors, correspondence or telephone calls to me. ☐

NAME OF INSURANCE COMPANY/THIRD PARTY PAYOR: [illegible]

I have read this consent/authorization/assignment statement completely.

Date	Time	Patient's Signature	Date	Time	Witness' Signature
MAR 07 2001	1040	x [signature]	MAR 7 2001	1040	[signature]
Date	Time	Patient's Representative Sig. (legal guardian/POA)	Relationship		
Date	Time	Telephone Consent By	Date	Time	Witness' Signature
			Date	Time	Witness' Signature
Date	Time	Guarantor's Signature	Relationship		

Admission Form 12/2000 - 140209

St. Mary's Regional Medical Center

Day Surgery Unit
History and Physical
Post Op Instructions

DAY SURGERY 3/09/01 1431040
MR 221342 MAILHOT, PAUL
SANTOZZI, RONALD M
40 POLAND RD
AUBURN ME 04210
DOB [redacted]/62 TEL 782-3873
00660 5921-02 3021616

ADDRESSOGRAPH

DATE	HISTORY
	PHYSICAL EXAM: VITAL SIGNS : T_____ P_____ R_____ B/P_____
	HEART:
	LUNG:
	OTHER:
Date & Time	**OP NOTE:**
3/9/01	PRE OP DX: (L) ureteral Calculus.
	POST OP DX: Same
	PROCEDURE: Cysto U - (L) Ureteral Stent Placement
	SURGEON: Mailhot ASSISTANT:
	EBL: ∅ DRAINS:
	COMPLICATIONS: ∅
	SPECIMEN:
	DISCHARGE INSTRUCTIONS:
	DISCHARGE ORDERS: Per Criteria
	DIET: As tol
	PHYSICAL LIMITATIONS: As Tol
	MEDICATIONS: Macrobid
	OFFICE VISIT: 10 Days
	FURTHER INSTRUCTIONS:

DAY SURGERY POST OP INSTR. (REV. 4/00)

PHYSICIAN SIGNATURE: Mailhot DATE: 3/9/01

ST MARY'S REGIONAL MEDICAL CENTER
Lewiston, ME 04240

HISTORY/PHYSICAL

1431040 22-13-42
FANTOZZI, RONALD M
DOB: [redacted]1962
PAUL R MAILHOT
Admitted: 03/09/2001

DICTATOR: PAUL MAILHOT, M.D.

CHIEF COMPLAINT: Kidney stone.

HISTORY OF PRESENT ILLNESS: This is a 38-year-old male with a long history of recurring ureterolithiasis secondary to Crohn's disease and secondary hyperoxaluria. He presented recently with a five-day history of left renal colic. He was seen in the Emergency Room where a spinal CT and KUB were performed revealing some retained left renal calculi as well as a left ureteral calculus. The calculus measured 2 to 3 mm but appeared to be causing significant discomfort. The patient also says that recently his Crohn's disease has been acting up, requiring OxyContin for pain control. He denies fever, chills, nausea, and vomiting. The patient is being admitted for left ureteroscopy with stone extraction with stent placement if indicated.

ALLERGIES: No known medical allergies.

SOCIAL HISTORY: The patient denies alcohol drinking or tobacco usage.

PAST MEDICAL HISTORY: Crohn's disease and a history of ureterolithiasis.

PAST SURGICAL HISTORY: Cholecystectomy, bowel surgery, and various procedures including ESWL for renal stone disease.

CURRENT MEDICATIONS: OxyContin, Luvox, Imuran, and Percocet.

FAMILY HISTORY: Mother is deceased of congestive heart failure. Father is alive and well.

REVIEW OF SYSTEMS: CARDIOVASCULAR: Negative. **PULMONARY:** Negative. **GASTROINTESTINAL:** As noted above. **MUSCULOSKELETAL:** Negative. **NEUROLOGICAL:** Negative. **ENDOCRINE:** Negative. **PSYCHIATRIC:** Mild depression.

PHYSICAL EXAMINATION: Reveals a well-developed, well-nourished white male in no acute distress. **SKIN:** Warm and dry. **HEENT:** Normal. **NECK:** Supple without masses or thyromegaly. **LUNGS:** Clear to auscultation bilaterally. **HEART:** Regular heart rhythm without murmurs or gallops. Pulses are equal. **ABDOMEN:** Shows diffuse right-sided abdominal tenderness, probably relating to the patient's Crohn's disease. There is some deep tenderness in the left upper quadrant, probably related to the patient's ureteral calculus. **BACK:**

1+ left costovertebral angle tenderness. **GENITALIA:** Normal uncircumcised penis and normal testes bilaterally. **RECTAL:** Normal prostate. **EXTREMITIES:** No cyanosis, clubbing, or edema. **LYMPH NODES:** None were palpable. **NEUROLOGICAL:** Grossly intact.

IMPRESSION:

1. Left upper ureteral calculus.
2. Left renal calculi.

TREATMENT PLAN: Left ureteroscopy with stone extraction if possible and left ureteral stent placement. The procedure, alternatives, risks, and possible complications have been explained to the patient.

PAUL MAILHOT, M.D./lgg

J: 92869
D: 03/08/2001 14:39:28
T: 03/08/2001 14:35:41

CC: MICHAEL MONZEL, M.D.
MICHAEL BOULANGER, M.D.

ST MARY'S REGIONAL MEDICAL CENTER
Lewiston, ME 04240

RADIOLOGY REPORT

FANTOZZI, RONALD M
Phone #(207)782-3873
DOB [redacted]/1962
Attending: PAUL R MAILHOT, M.D.
Referring: MICHAEL J BOULANGER
Visit #1431040
MR #22-13-42
X-Ray #08-99-89
Service Date 03/09/2001
NS/Room RD
Clinic Code: SD

ABDOMEN (2 views) 74020

Indication for Study: Placement of stent in OR.

FINDINGS: Compared with plain film of the abdomen on 2/24/01.

The osseous structures appear normal. The psoas margins are preserved as are the renal contours. A metallic clip is seen in the right upper abdominal quadrant.

The initial projection (scout) yields limited definition of the middle and upper pole of the left kidney.

A second projection with double J ureteral stent in satisfactory position outline a 2-3 mm calculus in the left middle renal pole and 1-2 calculi of similar size in the left upper renal pole.

IMPRESSION: Left ureteral stent in satisfactory position. Calculi identified in left middle and upper pole. Retrospectively, these appear unchanged since 2/24/01.

Lincoln T. Engstrom M.D.

LINCOLN ENGSTROM, M.D./lmb

J: 93109
D: 03/09/2001 14:19:41
T: 03/13/2001 03:55:25

CC: MICHAEL BOULANGER, M.D., Referring Physician
PAUL MAILHOT, M.D., Attending Physician

ORIGINAL

RADIOLOGY REPORT

ST MARY'S RE NAL MEDIC AL CENTER LEWISTON E 04240 7)777-8400
DAVID L.LICK, M.D., DIRECTOR, DEPARTMENT OF PATHOLOGY
RUN DATE: 03/08/01 PRE ADMISSION TESTING PATIENT REPORT PAGE 1
RUN TIME: 1606

DOCTOR
MAILHOT, PAUL R

Name: FANTOZZI,RONALD M 143104O Age/Sex: 38/M Admit. Dr: MAILHOT, PAUL R
Acct#: 1428274 Unit#: 000221342 Status: PRE IN Location: PAT
Reg: 03/07/01 Disch: D.O.B.: [redacted]1962 Phone: 207-782-3873

LEGEND: L=Low H=High CL=Critical Low CH=Critical High #=Delta >=New (A)=footnote

Ordering Dr: MAILHOT, PAUL R
Copy to Dr:

NON-STAFF PROVIDER ADDRESS

Specimen: 01;M0002499R COMP Collected: 03/07/01-1135
Source: URINE CC Sp Descrip: URINE-CC

Procedure	Result
	MICROBIOLOGY
URINE CULTURE Final	
COLONY COUNT	NEGATIVE COL/ML
NO GROWTH OBTAINED	

Patient: FANTOZZI,RONALD M Age/Sex: 38/M Acct#1428274 Unit#000221342

ST MARY'S RE NAL MEDICAL (ER LEWISTON E 04240 (20 77-8400
DAVID LICK, M.D., DIRECTOR, DEPARTMENT OF PATHOLOGY
RUN DATE: 03/07/01 PRE ADMISSION TESTING PATIENT REPORT PAGE 1
RUN TIME: 1606

DOCTOR
MAILHOT, PAUL R

143/040

Name: FANTOZZI,RONALD M Age/Sex: 38/M Admit. Dr: MAILHOT, PAUL R
Acct#: ~~1428274~~ Unit#: ~~000221342~~ Status: PRE IN Location: PAT
Reg: 03/07/01 Disch: D.O.B.: [redacted]/1962 Phone: 207-782-3873

LEGEND: L=Low H=High CL=Critical Low CH=Critical High #=Delta >=Now (A)=footnote

SPEC #: 0307:C00081R Collected: 03/07/01-1158 Ordering Dr: MAILHOT, PAUL R

Test	Result	Flag	Reference
	CHEMISTRY/CARDIAC/LIPIDS		
> CALCIUM	9.4		8.7-10.7 mg/dL
> GLUCOSE	88		70-110 mg/dL
> BUN	15		7-22 mg/dL
> CREATININE	0.9		0.6-1.3 mg/dL
> SODIUM	138		136-145 mmol/L
> POTASSIUM	4.1		3.5-5.1 mmol/L
> CHLORIDE	104		98-110 mmol/L
> CO2	28		23-33 mmol/L

SPEC #: 0307:H00067R Collected: 03/07/01-1158 Ordering Dr: MAILHOT, PAUL R

Test	Result	Flag	Reference
	HEMATOLOGY		
> WBC	6.6		4.5-10.9 10E3
> RBC	4.82		4.7-6.1 10E6
> HGB	14.6		14-18 g/dL
> HCT	44.1		42-52 %
> MCV	91.4		80-94 fl
> MCH	30.3		27-31 pg
> MCHC	33.1		33-37 %
> RDW	11.9		11.5-14.5 %
> PLT	320		130-400 10E3
> MPV	7.5		7.4-10.4 fl
> %LYMPHS (COULTER)	35.5	H	20-35 %
> %MONOS (COULTER)	12.7		0-15 %
> %GRANS (COULTER)	48.9	L	55-81 %
> %EOS (COULTER)	2.3		0-3 %
> %BASO (COULTER)	0.6		0-1 %

ST MARY'S RE[illegible]NAL MEDICAL [illegible]ER LEWISTON, E 04240 (20[illegible]77-8400
DAVID G[illegible]LICK, M.D., DIRECTOR, DEPARTM[illegible]T OF PATHOLOG[illegible]
RUN DATE: 03/07/01 PRE ADMISSION TESTING PATIENT REPORT PAGE 2
RUN TIME: 1606

DOCTOR
MAILHOT, PAUL R

1431040

Patient: FANTOZZI,RONALD M #1428274 (Continued)

SPEC #: 0307;HC00031R Collected: 03/07/01-1158 Ordering Dr: MAILHOT, PAUL R

Test	Result	Flag	Reference
	COAGULATION		
> PT	11.9		11.0-13.0 SECONDS
> INR	0.98		0.85-1.2
> APTT	31.2		24.0-34.0 SECONDS
> BLEEDING TIME	6.0		2.5-9.5 MINUTES

SPEC #: 0307;U00008R Collected: 03/07/01-1135 Ordering Dr: MAILHOT, PAUL R

Test	Result	Flag	Reference
	URINALYSIS		
> SPEC.REFRIGERATED?	NO		
> APPEARANCE	CLEAR		CLEAR
> COLOR	YELLOW		YELLOW
> SPECIFIC GRAVITY	1.021		1.008-1.030
> LEUKOCYTE ESTERASE	NEGATIVE		NEGATIVE
> NITRITE	NEGATIVE		NEGATIVE
> pH	7.0		5-8
> PROTEIN	NEGATIVE		NEGATIVE mg/dL
> GLUCOSE	NORMAL		NORMAL mg/dL
> KETONES	NEGATIVE		NEGATIVE
> UROBILINOGEN	NORMAL		NORMAL mg/dL
> BILIRUBIN	NEGATIVE		NEGATIVE
> OCCULT BLOOD	NEGATIVE		NEGATIVE ery/uL

Patient: FANTOZZI,RONALD M Age/Sex: 38/M Acct#1428274 Unit#000221342

ST. MARY'S REGIONAL MEDICAL CENTER

PRE-ANESTHETIC EVALUATION

DAY SURGERY 3/30/01 1431040
MR 221342 HAILEY, PAUL
FANTOZZI, RONALD M
42 POLAND RD
Ronald Fantozzi ME 04210

M F AGE 38 INTERVIEW DATE: 3.7.01 PROCEDURE DATE: 3.30.01 PHYSICIAN: [illegible]

HISTORY

CLINICAL DX: Ureteral Calculus
OP PROPOSED: Ureteral Stone Extraction Stent Placement
HISTORY OF PRESENT ILLNESS:

PREVIOUS ANESTHETICS/SURGERY: Paul Colleton ☐ NONE
COMPLICATIONS/REACTIONS: PONV GB ☐ NONE
FAMILY ANESTH. HISTORY: Stent ☐ NONE

SYSTEMS REVIEW
Cardiovascular (HPTN, CHF, Angina, MI): denies rare tachycardia
Pulmonary (Dyspnea, URI, COPD): mild DOE recurrent bronchitis
SMOKER: NO PACKS/DAY QUIT

RENAL
G.I. (Hiatal Hernia): chronic hx GERD
ENDOCRINE (Diabetes, Thyroid)
OTHER (Jaundice, Hepatitis, Abnormal Bleeding): Hepatitis C carrier

CURRENT MEDICATIONS: Oxycontin 30/40 Darvocet ☐ NONE
REACTIONS ☐ NONE
ALLERGIES: Ragweed ☐ NONE
MENTAL STATUS: Alert
TOBACCO, ETHANOL, OTHER DRUGS ☐ NONE
LAST ORAL INTAKE: NPO

PHYSICAL EXAM

VITAL SIGNS: BP 117/77 Sat 95% HR 88 RR Temp. Ht 5.8 Wt 77.3 (Kg)
GENERAL
AIRWAY: Mouth clear Teeth Neck, Jaw

LUNGS	HEART	SPINE, REGIONAL ANES. SITE	OTHER
CTA	RRR NL		

LABS

Hb 14 Hct 44 Pt Ptt Platelets
LYTES: Na Cl Gluc. K CO_2 BUN
CXR EKG
ABG: Ph PaO_2 $PaCO_2$ HCO_3
OTHER

PREMEDS/PLAN

Plan GAB LMA
R/B explained
Pt agrees verbally
Oxycontin 30mg PO this AM
A.S.A. Status 1 2 3 4 5 E
SIGNED M.D.

PRE-OP EVALUATION NOTES

B/P 110/70 Temp. 36.6 Pulse 90 Resp. 18
DATE 3/30 Time 9:45 A.S.A. Status 1 2 3 4 5 E
Evaluation Satisfactory YES ☑ NO ☐ COMMENTS:
SIGNED M.D.

DAY SURGERY POST-OP VISIT

TIME:
SIGNED M.D.

FE0005

Rev. 7/00

Ronald Fantozzi

ST. MARY'S REGIONAL MEDICAL CENTER
ANESTHESIA RECORD

SURGEON: W. P. Mailhot

ANESTH. NO. 1 2 3 4 5 E

PROCEDURE: Cysto, Left Ureteral Stent

PERMIT: Yes/No

M / F 58 AGE HT 5-8 WGT 171.3 lbs DATE 3/9/01

TECHNIQUE: ☐ G.A. ☐ REG. ☒ SPI. ☐ EPID. ☐ MAC

SHEET 1 OF 1

ALLERGIES: Hay fever

Hct.

: : SU-CE : : : : 1431C40
: 221362 : : : : : ST, PAUL
FANTOZZI, RONALD M
7C POLAND RD
/ UBURN ME 04210
DOB [redacted]/02 TEL 782-3873
00000392 1 02 3021616

PREMED: 10 · 11

														TOTALS
DRUGS	N2O/O2	6 L O2 —												
	Fentanyl	(2)(2)(1)												
	Versed	(1)(2)(1)												
	Propofol	30 20												
INFUSIONS		LR —												
MONITORS	EKG	SR	SR	SR										
	FIO2	1.0	1.0	1.0										
	SaO2	100	99	99										
	ETCO2	✓	✓	✓										
	Vt/RR													
	PIP/PEEP													
	TEMP													
	SvO2/c.o.													
	PAP/PCWP/CVP													
	PNS													
	TIME	10		X										

ANESTHESIA TIME: 0955 / 1035

SURGICAL TIME: 1005 / 1030

MACHINE # #2
EQUIP. CHECKED PRE-OP ☑

INTRA-OP EVENTS:
① Toprol #2, 300, Pre O2, Som IV sedation.
SAB: Sitting, betadine prep, drape, 1% lido skin, L3-4 mid-line, #24g Sprotte. Entry x1, clear CSF, no paresthesia, Inj Lidocaine 70mg c Epi wash p̄ all clear, neg aspiration. Supine to lith. TTS.

MONITORS
☑ EKG
☐ PCS
☑ ES
☑ FIO2
☑ SaO2
☑ ETCO2
☐ TEMP
☐ PNS

BP
☐ MANUAL
☐ NIBP
☐ A-LINE

OTHERS
☐
☐
☐
☐

150 — 100 — 50 —

for events: ① ②

KEY
ANES. x...x
OPER. ⊙..⊙
B/P V Λ
A-LINE I
PULSE •
RESP: SPONT ○, A Ø, C ⊗

FLUID									TOTALS
IV #1 (cc)									
IV #2 (cc)									
EBL (cc)									
URINE (cc)	UTA								
POSITION	Sit		Lith						

AIRWAY
☐ MASK ☐ OPA ☐ NPA
☐ ETT SIZE____ ☐ CUFF
☐ OR ☐ NAS ☐ TRACH
☐ DIR ☐ BLIND ☐ FIBER
TIME INT/EXT ______ / ______
BLADE ________ #ATT______
☐ BREATH SOUNDS EQUAL

VENTILATION, MISC
CIRCUIT | VENT TYPE
☐ HUMID ☐ HME ☐ BLD. WARMER
EYES: ☐ LUBE ☐ TAPE ☐ PADS

CATHETERS (☒ = IN SITU)

	TYPE	SIZE	SITE	☒
1				
2				
3				
4				

ARRIVAL PACU DATE 3/9/01 TIME 1035
B/P 124/55 PULSE 112 RESP. 16
REMARKS:

SIGNATURE

ANESTHETIST: B. Whalen

ATTENDING SIGNATURE: [signature]

FE0004

500685.011.0050

ST MARY'S REGIONAL MEDICAL CENTER
Lewiston, ME 04240

1431040 22-13-42
FANTOZZI, RONALD M
DOB: [redacted]1962
PAUL R MAILHOT, M.D.

OPERATIVE SUMMARY
(Day Surgery)

DATE OF OPERATION: 03/09/2001 Began: 1020 Ended: 1030

SURGEON: PAUL MAILHOT, M.D. ASSISTANT:

PREOPERATIVE DIAGNOSIS: Left ureteral calculus.
POSTOPERATIVE DIAGNOSIS: Left ureteral calculus.
OPERATION: Cystoscopy and left ureteral stent placement.

PROCEDURE AND FINDINGS: After adequate spinal anesthesia, the patient was prepared and draped in the dorsal lithotomy position. An abdominal scout film was taken revealing a faintly calcified stone between the transverse processes of L3 and L4 on the left. The stone appeared to measure approximately 6 mm to 7 mm in diameter. It was felt to be too high to extract; thus, it was decided to simply place a stent for the moment.

Cystoscopy was accomplished with a 22-French rigid panendoscope. The bladder was examined and found to be normal without evidence of tumor or calculus formation. A 6-French K/Wart ureteral stent was then inserted into the left collecting system and advanced without difficulty to the level of the renal pelvis. The stent was positioned such that the proximal pigtail was left in the renal pelvis and the distal pigtail was in the bladder. The stent was then internalized and another radiograph was taken. On the postoperative radiograph, the stone could no longer be visualized, suggesting that it was either pushed back into the kidney or that it was too faint to be seen on the second film. The patient tolerated the procedure well and was transferred to the PACU in satisfactory condition.

PLAN: The patient will be maintained on Macrobid 100 mg daily until seen in the office in 10 days. At that point, the stent will either be removed or the patient will be scheduled for further intervention, depending on the stone's position at that time.

PAUL MAILHOT, M.D./rlg

J: 93030
D: 03/09/2001 10:44:31
T: 03/12/2001 09:02:43
CC: MICHAEL BOULANGER, M.D.
MICHAEL MONZEL, M.D.

ORIGINAL

OPERATIVE SUMMARY

CONSENT TO OPERATION, THETICS, AND OTHER MEDICAL SERVICES

Date: 3-9-01 Time: 0845 DAY SURGERY 3/09/01 1431040
221342 MAILHOT, PAUL

1. I authorize the performance upon Ronald Patton (myself or name of patient) and of the following procedure
left ureteroscopy with stone extraction
left stent placement
performed by or under the direction of Dr. Mailhot

2. I consent to the performance of operations and procedures in addition to or different from those now contemplated, whether or not arising from presently unforeseen conditions, which the above named doctor or his associate or assistants may consider necessary or advisable in the course of the operation..

3. I consent to the administration of such anesthetics in connection with surgical or other medical procedures as may be considered necessary or advisable by any of the Anesthesiologists responsible for anesthesia services at this hospital to be administered by them or others under their supervision. The nature of the Anesthetics likely to be applied in any procedures that are about to be done has been fully explained to me by a physician, including the usual and most frequent risks and hazards encountered with those anesthetics unless I have asked that the physician omit or limit his explanations out of consideration for me.

4. The nature and purpose of the procedure, possible alternative methods or treatment, the risks involved, the possible consequences and the possibility of complications have been explained to me by Dr. Mailhot and Dr. _____. *(See below)

5. I acknowledge that no guarantee or assurance has been given by anyone as to the results that may be obtained.

6. I consent to the photographing or televising of the operations or procedures to be performed, including appropriated portions of my body for medical. scientific or education purposes. provided my identity is not revealed by the pictures or descriptive texts accompanying them.

7. For the purpose of advancing medical education, I consent to the admittance of observers to the Operating Room..

8. I consent to the disposal by the hospital authorities of any tissue or body parts which may be removed.

9. I am aware that sterility may result from the procedure. I know that a sterile person is incapable of becoming a biological parent.

10. I acknowledge that all blank spaces on this document have been either completed or crossed off prior to my signing. (CROSS OUT ANY PARAGRAPHS WHICH DO NOT APPLY)

PLEASE READ IN FULL BEFORE SIGNING AUTHORIZING SIGNATURES

Witness

Signature of Patient

If patient is unable to sign or is a minor, complete the following: Patient is a minor_____years of age. He/She is unable to sign because_____

Witness

Signature

Relationship

Patient's Name

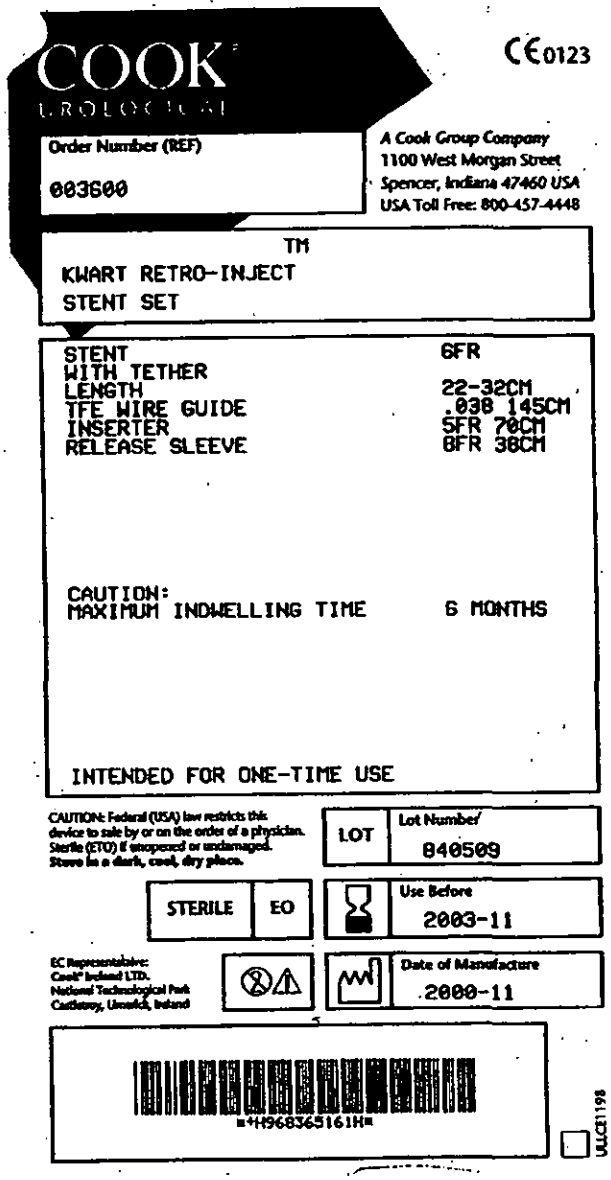
*I certify that the information in number 4 was given to

Physician's Signature

140026
ORCONSENT

500685.011.0052

1431040
Fantozzi, Ronald



St. Mary's Regional Medical Center
Pre-Op Admission Assessment

JAY SURGERY 3/09/01 1431040
MR 221342 HAILHOT, PAUL
FANTOZZI, RONALD H
40 POLAND RD
AUBURN ME 04210
DOB [redacted]/62 TEL 782-3873
006605921-02 3021616

Admission Date 3/9/1 Time 0945
Procedure Ureteroscopy w stone left
LOC Alert
Ventilating Well Yes ✓ No ____
Comments ____

	YES	NO	N/A
Pre-Admission Testing Reviewed	✓		
Abnormal Testing Report	✓		
PAT Anesthesia Visit	✓		
Pre-Op Teaching:			
Verbal instructions given, D.S. routine IV's Meds	✓		
Plan for Nursing Care Reviewed	✓		
Patient/Family express understanding of instructions	✓		
Emotional Support	✓		

Pre Surgery CheckList	YES	NO	NA
Doctor's orders noted and complete	✓		
Foley inserted if ordered			✓
Time voided ____ Cath drained ____ Amount ____			
Height 5'8" Weight 77.3			
Makeup, fingernail polish removed		✓	
Address-o-graph plate on chart	✓		
Dentures removed			
Jewelry removed/covered		✓	
Advanced directives on chart		✓	
IV ordered	✓		

Site LFT Cath 20G 1" By T Tomkiewicz RN

Signature B Poland RN/LPN

Pre-Op Medication

V/S prior to premeds T 96 P 92 R 18 BP 178/78
Pre-Medications ____

V/S post premeds P____ R____ BP____
P____ R____ BP____
P____ R____ BP____

Eye Drops to OD____ OS____
Ocufen .03% 1 Gtt on Adm____ & to OR____
Madriacyl 1% 1 Gtt Q5 min x4 ____ ____
____ ____
Mydfrin 2.5% 1 Gtt Q5 min x4 ____ ____
____ ____

Initials ____ Signature ____
Initials ____ Signature ____
Initials ____ Signature ____

Peri-Orbital Block

Monitor Pattern ____
Oxygen Saturation Pre ____ %
Versed mg. IV @____ by____ RN
Other Meds ____

Time____ BP____ P____ R____ SAT____ %
Time____ BP____ P____ R____ SAT____ %
Time____ BP____ P____ R____ SAT____ %
Time____ BP____ P____ R____ SAT____ %
Time____ BP____ P____ R____ SAT____ %
Oxygen started at ____/LPM via N/C Time____
Block To OS/OD by Dr.____ @____
Lid closed, taped, reducer in place P block ____
Block supplemented YES___ NO___ Time____
Signature____ RN/LPN

DAY SURGERY NURSING ASSESSMENT

DAY SURGERY 3/09/01 1431040
MR 221342 MAILHOT, PAUL
FANTOZZI, RONALD M
AND RD
AUBURN ME 04210
DOB 4/16/62 TEL 782-3873
1616

POST-OP PROCEDURE PHASE OF STANDARD CARE PLAN		TIME AND NUMBER PER CODE 1300	1330	1400
2 - Able to deep breath and cough 1 - Short of breath 0 - Apneac		2	2	2
2 - V.S. stable and within pt.'s normal limits 1 - V.S.'s irregular or fluctuating 0 - Unable to palpate B/p or pulse	B	2	2	2
2 - Extremities have full sensation Lower Rt/Lt, Upper Rt/Lt 1 - Extremities have partial sensation Lower Rt/Lt, Upper Rt/Lt 0 - Extremities are without sensation Lower Rt/Lt, Upper Rt/Lt	C	2	2	2
2 - Skin - Warm, Pink 1 - Skin Cool, Pale 0 - Skin - Cool, Cyanotic	D	2	2	2
2 - No surgical bleeding site 1 - Small amount of surgical bleeding 0 - Large amount of surgical bleeding	E	2	2	2
2 - Free of pain 1 - Minimal pain 0 - Moderate to severe pain	F	1	1	2
2 - Tolerating P.O. fluids 1 - Not taking P.O. fluids 0 - Nausea / Vomiting	G	2	2	2
2 - I.V. discontinues, Cath. Intact ____ ml. infused. 1 - I.V. patent @ KVO 0 - No I.V. ordered	H	1	1	2
2 - Voiding without problems 1 - Has not voided. 0 - Needs to be cathed.	I	1	1	2
2 - Fully awake 1 - Arouses when called 0 - Unresponsive	J	2	2	2
2 - Up ad lib 1 - Up with assistance 0 - On bedrest	K	[illegible]	[illegible]	2

TIME	TEMP	P	R	B/P	INIT	COMMENTS
1300		88	16	116/66	[illegible]	returned to room
1330	36⁵	92	16	119/78	MB	ambulated to door – no standing more comfortable
1500						voided 450 clear urine instructions given

TIME	MEDICATION - ROUTE	INIT	

Discharge Order by Surgeon Yes ✓ No ____ Cleared for discharge by Anes. Yes ✓ No ____
Seen by Surgeon ____
Discharge Teaching per Standard Care Plan to: Patient ✓ Family ✓ Other ____ Init. ____
D.C. Time & Mode WC 1510 Follow-up appointment [illegible] D.C. Criteria met: Yes ✓ No ____

Activity	(1) 2 3 4	Restrictions	(1) 2 3 4	
Diet	(1) 2 3 4	S/S Infection	(1) 2 3 4	
Drsg. Care	(1) 2 3 4	Complications		
		Written Rx.	(1) 2 3 4	

RESPONSE CODE
1 - Verbalizes understands
2 - Requires reinforcement
3 - Refuses
4 - N/A

Signature: [signature] Init. MB

500685.011.0055

St. Mary's Regional Medical Center
Perioperative Nursing Record

DAY SURGERY 3/09/01 1431040
R 221342 MAILHOT, PAUL
ANTOZZI, RONALD H
0 POLAND RD
AUBURN ME 04210
DOB [redacted]/62 TEL 782-3873
006605921-02 3021616

Date: 3/9/01 OR Room #: 2 Room Temp: 20
Surgeon: Mailhot Asst.:
Anesthesiologist: Lagens CRNA: T. Robal
Relief: Relief:
Circulator: Hesomley Scrub: T. Chabot SNP
Relief: Schaefer In 1005 Out 1025 Relief: In Out
Relief: In Out ASA: 2 Wound Class: 2
Pre-Op Dx: Left ureteral calculus

PRE-OP ASSESSMENT

HOLDING ROOM: 0905

TRANSPORTED FROM: ☑ DS ☐ ICU ☐ ED ☐ Nursing Unit ☐ Other

☑ CONSENT: Verified with schedule, patient, surgeon, H&P.
OP Site marked by Surgeon: ☐ Yes ☐ No ☑ N/A

H + P: ☑ YES ☐ NO ☐ Consult
Comments

ENTER OR: 955
INDUCTION COMPLETION: Spinal
INCISION: 1020
CLOSURE: 1030
LEAVE OR: 1035

PT STATEMENTS: NPO Since 8PM Allergies hay fever
LOC: ☑ Alert ☐ Oriented ☐ Drowsy ☐ Intubated ☐ Other

SENSORY RESTRICTIONS: VISION: ☐ None ☑ Glasses ☐ Other
HEARING: ☑ None ☐ HoH ☐ L ☐ R ☐ Other

MOBILITY RESTRICTIONS: ☑ None ☐ Traction ☐ Non-Ambulatory ☐ Other
SKIN CONDITION: ☑ Warm/Dry/Intact ☐ Other

EMOTIONAL: Level of Anxiety ☑ Relaxed ☐ Anxious ☐ Crying
CULTURAL/PSYCHOSOCIAL: Pertinent Info for Plan nothing pertinent

IV'S: ☑ Peripheral ☐ Central ☐ Swan ☐ Epidural ☐ Pre-Op Antibiotics
Inserted By T. Timberlake ☐ Came With
BLOOD: ☑ NA ☐ Screen Only ☐ X-Match ☐ Autologous
Units ☐ Other

LAB TESTS: ☐ CBC/HH ☐ Lytes ☐ UA ☑ PT/PTT ☐ Glucose ☐ CMP ☐ BMP ☐ Platelets ☐ Other
☑ EKG ☐ ECHO ☐ Other ☐ EKG ☐ PFT'S

PLAN: Provide emotional support

Signature [illegible signatures]

INTRA-OP ASSESSMENT

EQUIPMENT: ☐ NA ☑ Safety Strap ☐ VACPAC ☐ Bair Hugger # ☐ Cloward Saddle ☐ Eye Stretcher
☐ Sand Bag ☐ Prone Pad ☐ Mayfield ☐ Leg Holder ☐ Stirrups ☑ Cysto Table
☐ Kidney Bar ☐ Horseshoe Headrest ☐ TED Stockings ☐ CUSA ☐ Stealth ☐ Fx Table
☐ Footboard ☐ Lat/Reg Armboard ☐ SCD/EPCS ☐ Adhesive ☐ Other

POSITION: ☐ Supine ☑ Lith ☐ Prone ☐ Lat __R↑ __L↑ ☐ Mod Knee-Chest ☐ Beach Chair ☐ Other
PADDING: ☐ NA ☑ Pillow/limbs ☐ Axillary Roll ☐ Gel ☐ Headrest, donut
Position Verification: @ 1020 : ok ; @ : ; @ : ; @ :

[illegible]

ELECTROSURGERY: ☑ NA ☐ Bipolar# Setting
☐ Monopolar# Coag Cut Pad Site Lot#

SURGICAL PREP: ☐ NA ☐ Shave ☑ Soln ☑ Scrub ☐ Gel ☐ Dura ☐ Eye ☐ Alcohol ☐ Hibiclens ☐ Iodine
☐ Other Prep Site perineum By Schaefer

TOURNIQUET: [illegible]

IRRIGATION: ☐ NA ☐ NS ☐ NEO ☐ L/R ☑ H_2O ☐ BSS
☐ HepNS ☐ Glycine ☐ Baci ☐ Gent ☐ Other

[illegible]

FAMILY COMMUNICATION: [illegible]

COMMENTS: [illegible]

St. Mary's Regional Medical Center
Perioperative Nursing Record

DAY SURGERY 3/09/01 1431040
221342 MAILHOT, PAUL
FANIOZZI, RONALD M
40 POLAND RD
AUBURN ME 04210
DOB [redacted]/62 TEL 782-3873
006605921-02 3021616

INTRA-OP ASSESSMENT (CONT.)

GASTRIC TUBE: [illegible]
[illegible]

MEDICATION: ☒ NA ☐ Dye ______
☐ Ungt ______ ☐ Other ______
☐ Drops ______
☐ Injection ______
#ml's ______ Site ______

SURGICAL IMPLANTS: ☐ NA ☒ Implanted ☐ Stickers on Back ☐ See Charge Sheet
Type/Co Cook Knot Stent Size 6F Lot# 840569 SN ______ ☐ Removed ______

SPECIMEN: ☒ No Specimen ☐ Not Sent
1. ______ FO / FR / FS
2. ______ FO / FR / FS
3. ______ FO / FR / FS
4. ______ FO / FR / FS
5. ______ FO / FR / FS

☐ Cultures / Gram Stain ☐ Sentinel Tissue Reading ______
1. ______ Disp. of Spec. ☐ Lab ☐ Xray
2. ______

COUNTS: ☒ NA ☐ Correct ☐ Incorrect

				Initial	Final	Relief
Sponge	☐ YES	☐ NO	☐ Aborted	Circ ______	______	______
Sharp	☐ YES	☐ NO	☐ Aborted	Scrub ______	______	______
Instrument	☐ YES	☐ NO	☐ Aborted	Comments ______		☐ Surgeon Notified

DRAIN: [illegible]

DRESSING: ☒ NA ☐ Xeroform ☐ 4 x 8's ☐ Telfa ☐ ABD
☐ Coverlets ☐ Bandaids ☐ Eye Patch ☐ ______

ANESTHESIA: ☐ Gen ☒ Spinal ☐ L/MAC
☐ Regional ☐ Epidural ☐ Local

☒ EBL min

DISCHARGE TO: ☒ PACU ☐ Unit ______
Transfered Via: ☒ Stretcher ☐ Bed ☐ ______
PT STATUS: ☒ Stable ☐ Unstable ☐ ______

POST-OP ASSESSMENT

POST OP DX: Left ureteral calculus
PROCEDURE: Left ureteroscopy with Left ureteral Stent placement, Cystoscopy

PT OUTCOME /INTERVENTIONS: YES NO
☒ ☐ Alignment maintained ______
☒ ☐ Proper ground pad placement noted NA
☒ ☐ Skin integrity intact NA
☒ ☐ Aseptic technique maintained ______
☐ ☐ Other identified outcomes ______

NURSING NOTES:

SIGNATURE OR: [signature] RELIEF: ______

OR PERIOPERATIVE NSG RECORD 2 part W/C NCR (Rev. 8/00) PAGE 2 OF 2

500685.011.0057

St. Mary's Regional Medical Center
DOCTOR'S ORDER FORM

Diagnosis:

Drug Allergies:

DAY SURGERY 3/09/01 1431040
MR 221342 MAILHOT, PAUL
PANTOZZI, RONALD M
40 POLAND RD
AUBURN ME 04210
DOB [redacted]/62 TEL 782-3873
006605921-02 3021616

Addressograph Imprint

☐ In Accordance with Our Formulary System The Use Of Generic Equivalents Acceptable Unless Box Checked.

Doctor's Order Form Instructions For Use:

1. Imprint Before Placing In Chart.
2. Fax To Pharmacy Each Time The Doctor Writes A Set Of Orders.
3. Indicate Fax Orders By Placing Initials In Column Opposite Doctor's Signature.
4. The Signature Of A Doctor Must Accompany Each Set Of Orders.

Date	Time	Post Anesthesia Care Unit Physician's Orders	Initial When Faxed
		1. Oxygen: ☐ Face Tent FIO2 _____ %	
		☐ Nasal Cannula	
		2. Nebulizer Treatment in PACU: ☐ Albuterol ☐ Mucomist ☐ _____	
		3. Pulse Oximetry Post-op	
		4. Intravenous Fluids in PACU:	
		☒ Continue with present IV of LR at 100 cc/hr	
		☐ Follow present IV with same solution	
		5. Pain Medication (if no allergy) in PACU:	
		☒ Morphine Sulfate 1-4 mg IV q5 min PRN, max dose of 0.1mg/kg	
		☒ Meperidine 12.5-25mg IV q5 min PRN, max dose of 1mg/kg	
		Notify Anesthesia when max dose is reached and patient continues to experience pain.	
		6. Antiemetic (if no allergy) in PACU:	
		☐ Metoclopramide 10 mg IV	
		☐ Ondansetron 4 mg IV	
		☐ Prochlorperazine 5-10 mg IV PRN w/max dose of 10 mg	
		7. Accucheck while in PACU: ☐ q 1 hour If Insulin Dependent Diabetic	
		8. Return to room when patient meets discharge criteria.	
		(9) Give Toradol 30mg IV now in PACU	
		(10) Give Vistaril 50mg IM now in PACU	
		(11) Give Benadryl 25mg - 50mg IV now in PACU	
		NOTED 3-9-01 KM Jennifer R	

Signature of Responsible Anethesiologist

DOCTOR'S ORDER FORM
PACU PHYSICIAN'S ORDERS
Rev. 12/00

ORIGINAL FOR CHARTS
DOCTOR'S ORDER FORM

St. Mary's Regional Medical Center
POST ANESTHESIA CARE UNIT RECORD

DAY SURGERY 3/09/01 1431040
MR 221342 MAILHOT, PAUL
FANTOZZI, RONALD M
40 POLAND RD
AUBURN ME 04210
DOB [redacted]62 TEL 782-3873
006605921-02 3021616

Admit Date: MAR 9 2001 Via: ☐ Stretcher ☐ Patient Bed ☐ Siderails Up ☐ Padded ☐ TEDS ☐ Flowtrons

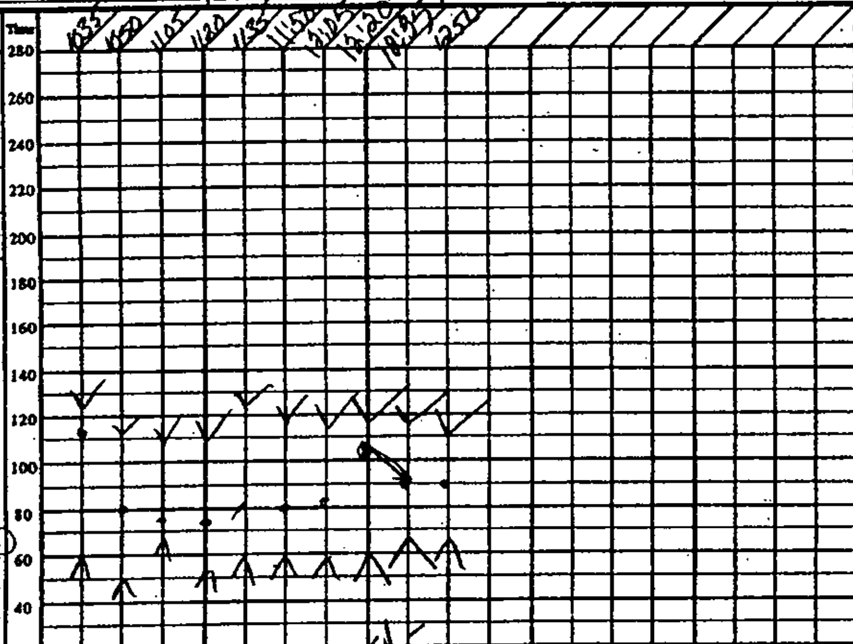
Procedure: (L) ureteral stent placement cystoscopy

Time In: 1035 Time Out: 1255

Preop VS: BP 117/77 P 58 O2 Sat 95%

Allergies: Hayfever

Patient History	Pt. Medication	Intra-Op Anesthesia
Crohn's	Oxycontin	☐ General Mask ☐ General ETT ☒ Spinal ☐ Local ☐ Epidural ☐ LMA ☐ Block
paroxysmal tachycardia	Hydromorphone (?)	Agents Used: Fent, Versed
recur. bronchitis	Lomotil (?)	Sedation: Prop
		Reversals Used:
		Intra-Op V.S.: 120-130/60-80 / 90
		Meds Given:
		Other:



Legend: Pulse •, Systolic V, Diastolic Λ, Cuff; A Line x; Ax: Axillary; R: Rectal; O: Oral; T: Tympanic; Temp. 38 Ax

Times: 1035, 1050, 1105, 1120, 1135, 1150, 12:05, 12:20, 12:35, 1250

Respirations	16	16	16	16	16	16	16	16	
O2 Sat	96	97	97	97	98	98	97	98	
FIO2	RA	RA	RA	✓	✓	✓	✓	RA	RA
Spinal Level	T10	✓	T11	✓	✓	T12	✓		
CVP									
P.A.P./P.A.W.									
EKG Rhythm		ASR							

ALDRETE SCORE

Criteria	Score	
move 4 extremities	2	activity
move 2 extremities	1	
move 0 extremities	0	
deep breaths & cough	2	respiration
dyspnea or limited	1	
apnea	0	
B/P +/- 20% pre-op	2	circulation
B/P +/- 20%-50% pre-op	1	
B/P +/- 50% pre-op	0	
fully awake	2	consciousness
arousable	1	
non-responsive	0	
Able to maintain O_2 saturation >92% on room air	2	O_2 Saturation
Needs O_2 inhalation to maintain O_2 saturation >90%	1	
O_2 saturation <90% even with O_2 supplement	0	

	IN		OUT
Muscle Activity	1	2	2
Respirations	2	2	2
Circulation	2	2	2
Consciousness	2	2	2
O2 Saturation	2	2	2
Total Score	9	10	10

Medication Record

1125 Vistaril 50mg IM 5 KH

Time	Drug	Dose	Route/Site	Pain Scale	Initial
1040	MS	2mg	IV	5	KH
1055	MS	3mg	IV	5	KH
1105	MS	2mg	IV	5	KH
1115	Toradol	30	IV	—	KH
1115	Demerol	50	IV	5	KH

Pain Scale
5 Worst
4
3
2
1
0 No Pain

Nurse's Signature	Init.	Nurse's Signature	Init.	Nurse's Signature	Init.
				Kathleen Henning RN	KH

PACU RECORD
Rev. 12/00 Page 1 of 4

500685.011.0059